

Preventive Health Check-Ups: Between the Promise of Certainty and the Uncertainty of What Lies Ahead

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ABSTRACT

Uncertainty permeates medical practice, yet it is often concealed beneath promises of certainty and control. This article invites reflection on how physicians and patients relate to uncertainty, and how communication and the therapeutic relationship can become central tools of care when no clear answers are available. Written from and for primary care, it uses a clinical vignette to raise questions that may enrich everyday practice.

Keywords: uncertainty, primary health care, cultural beliefs, patient-centered care, health communication, physician-patient relations.

Chequeos preventivos: entre la promesa de certeza y la incertidumbre del devenir

RESUMEN

La incertidumbre atraviesa la práctica médica, aunque muchas veces se la oculta bajo promesas de certeza y control. Este artículo propone reflexionar sobre cómo médicos y pacientes se relacionan con lo incierto, y cómo el vínculo y la comunicación pueden transformarse en herramientas centrales de cuidado cuando no hay respuestas claras. Escrito desde y para el primer nivel de atención, parte de una viñeta clínica para plantear interrogantes que enriquezcan la práctica cotidiana.

Palabras clave: incertidumbre, primer nivel de atención, creencias culturales, cuidados centrados en el paciente, comunicación en salud, relación médico-paciente.

INTRODUCTION

The purpose of this article is to reflect on the role of uncertainty in contemporary medical practice and on how the ways in which physicians and patients relate to it influence clinical decision-making, communication, and the experience of care. Drawing on a clinical vignette and insights from the literature on uncertainty in medicine, we will raise questions aimed at enriching the reader's reflections.

We also seek to critically examine the pursuit of certainty that currently permeates the everyday practice of many of us and to explore how this shapes our patients' expectations. At the same time, we aim to explore alternatives that may allow uncertainty to be embraced in a more honest, humane, and shared manner.

It is important to emphasize that this text is written by two family physicians, from and for the primary care setting, where many of the consultations we conduct

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revolve around health maintenance and preventive health check-ups. Therefore, the ideas presented here may not apply uniformly or universally to other areas of medicine, where the degree of urgency and the need for certainty may differ.

EXPECTATIONS REGARDING HEALTH

We all have expectations, and those expectations shape our experiences, the decisions we make, and how we feel about the outcomes of those decisions.

When it comes to preventive health check-ups, patients often believe that the more interventions are performed, the better. They expect that a greater number of tests and treatments will translate into better health outcomes.¹ However, the evidence shows that this is not necessarily the case. In recent years, evidence has emerged suggesting that periodic health check-ups do not appear to provide the net benefit we once attributed to them.² Moreover, in some cases, the harms resulting from interventions outweigh their expected benefits. The mechanisms through which such harms may arise are numerous and include overdiagnosis, overtreatment, false-positive results, diagnostic cascades, anxiety, financial and time costs, and labeling effects, among others.³

Physicians also tend to hold unrealistic expectations regarding the benefits and risks of the tests and treatments we recommend, which may contribute to the overuse of interventions. A systematic review showed that we frequently overestimate benefits and underestimate harms, while accurate estimates are relatively uncommon.⁴ This issue is further exacerbated when healthcare decisions are driven more by market forces and/or economic interests than by the available scientific evidence.⁵

Physicians and patients are both part of the same health culture, one that promises a (possibly false) sense of security to those who follow its recommendations.⁶ The implicit message is often: *“If you undergo the check-ups we recommend, you will remain healthy.”* This message, more coercive than compassionate in tone, departs from the genuine advice of someone accompanying a patient along their journey. It also carries a dangerous counterpart: *“If you do not do what we tell you and you become ill, then it is your fault.”* In this way, illness ceases to be understood as a complex phenomenon and instead becomes a punishment for failing to follow the rules.

Regardless of the expectations that patients may have and the expectations that physicians may hold regarding what it means to “take good care of one’s health”, both parties often share a common expectation: they both want the patient to do well. The question that arises –and that frames the remainder of this article– is what we do when things do not go well.

A CLINICAL VIGNETTE: WHEN CHANCE INTERRUPTS ROUTINE

Martín was the kind of patient one might describe as “very healthy.” At 65 years of age, he exercised regularly,

did not smoke, and had no significant medical history. Every year, around the same time, he diligently attended his routine health check-up. However, at his most recent visit, he arrived pale and complaining of asthenia. Laboratory testing revealed a hemoglobin level of 9 g/dL, and subsequent evaluation led to a diagnosis of leukemia.

Following the diagnosis, Martín began asking questions: *“Why is this happening to me? I always did everything right... What did I do wrong? Could it have been the radiation from cell towers? Contaminated water containing pesticides? Or was it because my doctor did not monitor me adequately?”*

Physicians also tend to ask themselves questions in situations like this: *“If I had ordered blood tests earlier, would I have detected it in time? Would it have changed the prognosis? Should I start ordering tests more frequently, even though the available evidence does not recommend doing so?”*

Both sets of questions share a common root: discomfort with what we cannot control.

UNCERTAINTY IN MEDICINE: DIFFERENT LEVELS, DIFFERENT APPROACHES

In our view, there are different types of uncertainty related to medical practice (Fig. 1). One is associated with gaps in knowledge regarding diagnostic and/or therapeutic issues and can be addressed through access to and appraisal of the scientific evidence and accumulated clinical experience. Another arises when attempting to apply that general knowledge to a particular patient, with their own history, values, and context. A third type (and the one to which this article primarily refers) is of a different nature: the uncertainty linked to each patient’s future course, to the impossibility of predicting with certainty how a person’s health or illness will evolve, or what direction a life will take.

This type of uncertainty is the thorn in the side of a culture that has grown accustomed to being offered certainty. Although we live in a world where technology, artificial intelligence, and cutting-edge treatments promise precision and control, cases such as Martín’s remind us that chance and unpredictability continue to shape the course of life. Uncertainty remains inherent both to the human condition and to the practice of medicine.

WHAT CAN WE LEARN FROM EXPERIENCES LIKE THIS?

We propose several approaches that may help enrich our relationship with uncertainty in everyday clinical practice:

1) Avoid cognitive errors when confronted with exceptional cases

One of the most common reactions to unexpected situations such as the one described is the tendency to generalize from a single case. A physician faced with the diagnosis of a serious illness may feel tempted to modify their practice for example, by ordering more tests or requesting them more frequently for all patients. However, such responses may reflect an emotional

UNCERTAINTY IN MEDICINE

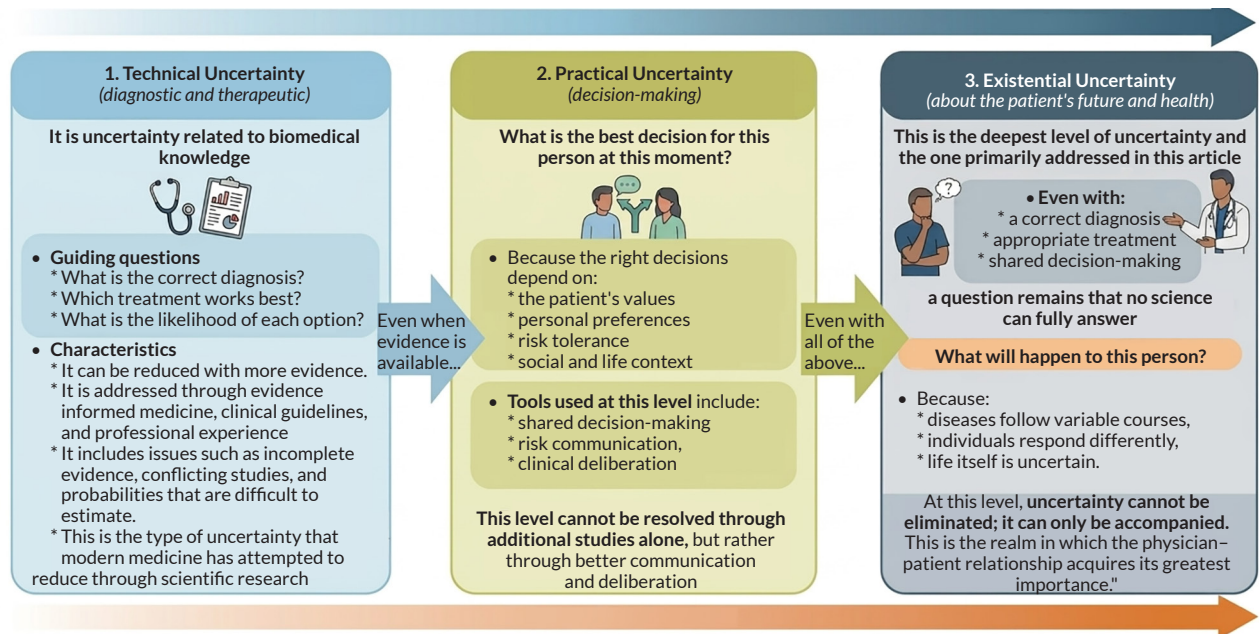


Figure 1. Types of uncertainty physicians may encounter in clinical practice.

reaction to the event rather than a decision grounded in evidence.

From a statistical perspective, rare events continue to occur despite their low probability: unlikely is not the same as impossible. The occurrence of a single exceptional case should not necessarily lead to changes in general medical practice. Adopting a different approach based on rare events may result in a more interventionist form of medicine, increasing the risk of overdiagnosis, false-positive results, and overtreatment.

Tools such as evidence-based medicine and an understanding of health and disease in probabilistic terms allow these events to be placed in context and help prevent decisions from being guided solely by recent experiences and the emotions they may have generated in us.⁷

2) Living with uncertainty without passivity or excess

Uncertainty is a central and unavoidable component of medical practice. William Osler, one of the fathers of modern medicine, stated that “*medicine is a science of uncertainty and an art of probability,*” acknowledging the intrinsic limits of our knowledge.⁸ Denying this reality only leads to frustration, burnout, and, often, to a more defensive form of medicine rather than one centered on patients.

When we learn to coexist with uncertainty, we also learn to offer something valuable to those under our care: reassurance. Our role should not be to mirror the patient’s distress in the face of the unknown. Instead, it may be precisely to provide a calm presence that helps reframe what is happening.⁹

Some authors have argued that developing the ability to tolerate uncertainty is one of the core competencies of contemporary medicine.¹⁰ Studies have shown that the way healthcare professionals relate to uncertainty influences their diagnostic performance.¹¹ Therefore, learning to manage uncertainty contributes to better practice not only from a relational perspective but also from a technical one.

At this point, we are compelled to revisit the question: what does it mean to “manage uncertainty well”? In the previous section, we saw that, in the absence of certainty, we may be inclined to do too much. Conversely, there may also be a tendency to assume that accepting uncertainty means adopting a passive attitude or refraining from intervention while simply waiting to see how a given situation unfolds.¹² Proper management of uncertainty entails neither inaction nor excessive medical intervention, but rather the ability to recognize its different levels and to act in proportion to the information available.

In what could aptly be termed “**academic**” uncertainty—that is, uncertainty related to diagnostic and therapeutic knowledge—there are structured strategies that can help address it. For example, the RAPS framework (*Recognize, Acknowledge, Partner, Seek Support*) proposes recognizing uncertainty, explicitly acknowledging it, partnering with the patient, and seeking support when necessary.¹³ This type of approach does not paralyze clinical action; on the contrary, it allows decision-making to continue while strengthening the therapeutic alliance.

There is, however, another form of uncertainty that no scientific advance can fully eliminate: the impossibility

of predicting with certainty the future course of an individual patient. Medicine can estimate probabilities, but it cannot guarantee individual outcomes. In this context, it is useful to revisit both our own expectations and those of our patients regarding what preventive health check-ups are expected to achieve. Doing so may help redirect our shared efforts toward the promotion and construction of health, rather than toward attempting to control every variable in order to prevent patients from becoming ill. This shift is essential if we wish to move beyond the notion of health as merely the absence of disease and instead embrace it as a state of physical, mental, and social well-being, as proposed by the **World Health Organization (WHO)**.¹⁴

3) The therapeutic relationship as a tool for care

In a landscape shaped by probabilities, decisions, and the limits of knowledge, the physician–patient relationship assumes a central role as a regulator of the anxiety generated by uncertainty. Studies have shown that the quality of the therapeutic relationship influences not only patient satisfaction but also treatment adherence and health outcomes.¹⁵ In contexts where definitive answers do not exist, the presence of a healthcare professional who is willing to accompany, listen to, and support the patient throughout the process can become an important source of emotional reassurance.⁹

Another practical way to strengthen the physician–patient relationship is by promoting patient empowerment within the care process. Strategies such as *shared decision-making* enable individuals to actively participate in choosing among diagnostic or therapeutic options, integrating the best available evidence with their own values, preferences, and life circumstances.¹⁶ Within this approach, the physician ceases to be merely a prescriber and instead becomes a facilitator of informed decisions, transforming uncertainty into a space for collaboration and shared care.

For this type of relationship to fully develop, it is essential for the medical community to strengthen its communication skills. Traditional medical training has placed great emphasis on diagnosis and treatment, but has often neglected the systematic teaching of communication competencies. The ability to explain probabilities, explore values, and support decision-making processes in contexts of uncertainty is now a core clinical skill.¹⁷

Physicians should strive to move from a communication style based on certainty to one grounded in *reality: life understood as a range of possibilities*. Freely available resources, such as the book *Know Your Chances*, teach how to communicate risk as a matter of *possibility* rather than *danger*.¹⁸ Within this framework, what changes is not only the way information is conveyed, but also the role offered to the patient. Rather than being positioned as either guilty or obedient, patients become active participants in shared decision-making from a more informed and autonomous standpoint.

It may also be useful for us to reexamine our own expectations regarding our role in our patients' lives. If what we hope for is that our patients do well, perhaps we should also reflect on what *doing well* actually means. Does it mean never becoming ill? Never experiencing suffering, let alone death? Or does it mean being accompanied in an ethical and committed manner, even when there are no clear answers about what lies ahead?¹⁹

Finally, we wish to emphasize the importance of reflecting on the role each of us plays within contemporary medical culture. When we promise health in exchange for compliance – “*if you do what we tell you, you will be fine*” – we reinforce a logic of control and offer guarantees that we are ultimately unable to provide.

A NOTE ON PRIMARY CARE

It is worth returning to a point mentioned in the Introduction. Primary care is the ideal setting in which to address this type of uncertainty, not only because preventive care is concentrated there, but also because it is the only context in which the time and continuity required to build the relationships proposed in this article as a central tool are generally available. The longitudinal nature of the physician–patient relationship in family medicine allows clinicians to know individuals before illness appears and to accompany them when a diagnosis arrives unexpectedly. It is within this fabric of repeated encounters that calmness, honesty, and shared decision-making can make a meaningful contribution to the quality of care provided.

FINAL CONSIDERATIONS

We firmly believe that, in today's world, what is truly revolutionary in medicine is no longer the promise of new technologies or guaranteed outcomes, but rather *the willingness to say what patients need to hear, even when it is not what they wish to hear*. Accepting that not everything is preventable and that not everything can be controlled is an act of honesty that runs counter to prevailing cultural expectations, yet it may represent the seed of a better culture. It means abandoning impossible promises and beginning instead to build relationships grounded in truth, respect, and shared care.

Accepting uncertainty is not synonymous with surrender. Rather, it is a form of professional maturity. Embracing uncertainty replaces the illusion of unattainable certainty with something more real and more valuable: the therapeutic relationship. A stance of “*I will accompany you, whatever may come*” ultimately lies at the heart of the care we provide.

Embracing uncertainty does not make us any less of a physician. On the contrary, it makes us more aware, more honest, and perhaps wiser. Because in the end, what truly helps is not certainty, but a relationship that endures even when there are no longer any answers.

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